New Nouveau Brunswick

LONG TERM DISABILITY / WAIVER OF PREMIUM EMPLOYEE STATEMENT CHECKLIST

IT IS YOUR RESPONSIBILITY TO ENSURE THAT YOU HAVE COMPLETED THE FOLLOWING STEPS BEFORE SUBMITTING YOUR CLAIM FOR BENEFITS.

To qualify for benefits you must meet the definition of 'Total Disability' and premiums must be continued (paid) for four (4) months following the date your leave started.

✓ Check the following:

- ○ I have answered all the questions on the Employee Statement.
- ○ I have attached a copy of my birth certificate.
- ○ I have continued my premiums through payroll deductions during my leave with pay (if applicable); and/or
- ○ I have completed the Continuation of Employee Benefits form for the benefits I want to continue during my leave without pay (if applicable), and
- ○ I have provided Vestcor and/or my Employer with post-dated cheques or money orders for the benefits I want to continue during my leave without pay per the instructions on the Continuation of Employee Benefits form.

****IMPORTANT****

Vestcor must receive the completed Continuation of Coverage form and post-dated cheques or money orders within 60 days from the date your leave without pay started. Otherwise, your claim and cheques may be returned, and you will not be eligible for the Long Term Disability and/or Waiver of Premium benefits.

If you have any questions, contact the Member Services Team at Vestcor at (506)453-2296 or 1-800-561-4012

New Nouveau Brunswick

EMPLOYEE STATEMENT - APPLICATION FOR BENEFITS
☐ **LONG TERM DISABILITY (LTD) BENEFITS**
☐ **CONTINUATION OF COVERAGE DURING DISABILITY (WAIVER OF PREMIUM)**

Complete and return to: Vestcor
P.O. Box 6000, Fredericton, NB E3B 5H1
Telephone: (506) 453-2296 Toll Free in Canada: 1-800-561-4012 Fax: (506) 457-7388

1. EMPLOYEE INFORMATION (Please Print)

Name (first/last)	
☐ Male ☐ Female	Date of birth (attach copy of birth certificate) (DD/MM/YY)
Social Insurance Number (Optional)	Vestcor Reference Number **OR** Employee Number
Employer (name department, agency, hospital, school district or other)	Latest Occupation

2. APPLICATION FOR BENEFITS INFORMATION - Please identify which benefits you are claiming.

a) ☐ Long Term Disability (LTD) Benefits

b) ☐ Continuation of coverage while disabled - please indicate which plans apply:

☐ Basic Life and AD&D Insurance ☐ Long Term Disability Plan ☐ Voluntary AD&D

☐ Optional Life and AD&D Insurance ☐ Dependant Life Insurance

☐ Health and/or Dental Plans → Policy # _____ Identification # _____
(Located on your Medavie Blue Cross ID card)

c) ☐ Disability Pension (under Teacher's Pension Plan only)

3. INCOME/BENEFIT INFORMATION

Are you receiving salary continuation (paid sick leave, vacation) from your employer? ☐ Yes ☐ No If yes, to what date? (d/m/y) _____

Have you applied for Disability Benefits from the Canada Pension Plan or the Quebec Pension Plan? ☐ Yes ☐ No

Is this claim the result of a work related injury/illness - past or present? ☐ Yes ☐ No

Has a claim been filed under the *Worker's Compensation Act*? ☐ Yes ☐ No

If yes, are benefits payable? ☐ Yes ☐ No ☐ Decision Pending

Is this claim the result of a motor vehicle accident? ☐ Yes ☐ No

If yes, is there any legal action involved? ☐ Yes ☐ No

If yes, please provide lawyer's name and address: _____

Are you claiming or receiving salary replacement disability benefits from another group insurance, association or franchise plan? ☐ Yes ☐ No

If yes, name of insurance company: _____ Policy Number: _____

Continued on the next page

4. MEDICAL INFORMATION AND WORK INFORMATION

When did symptoms begin that developed into your present medical condition? _____

From what date has your condition prevented you from working? (d/m/y) _____

Describe your present medical condition, its cause and history. (If you were injured as a result of an accident, describe what happened, when and where it took place.) _____

_____

_____

_____

Which of your regular job functions could you still fulfill? _____

_____

Which of your regular job functions could you not fulfill? _____

_____

Have you attempted to return to work? ☐ Yes ☐ No

If yes check where applicable ☐ full-time ☐ part-time ☐ regular duties ☐ modified duties ☐ other employer

If no, when do you expect to return to your regular occupation? (d/m/y) _____ any other occupation? (d/m/y) _____

Have you previously claimed long-term disability or continuation of coverage benefits under benefit plans for Employees of the Province of N.B.? ☐ Yes ☐ No

Have you had a similar injury or illness in the past? ☐ Yes ☐ No

If yes, describe, including original date and if any leave was taken from work: _____

_____

_____

Please provide any additional information that you believe should be considered in assessing your claim. (Attach additional sheets if needed.) _____

_____

_____

5. MEDICAL INFORMATION

To reduce delays in the assessment of your claim, attach all available test results, consultation reports and hospital discharge summaries - in addition to the Attending Physician Statement.

List all Physicians (including any other specialist or health care practitioner) that you have seen for your present medical condition.

Name of Physician/ Specialist	Type of Practitioner	Address	Date of 1st visit	Date of next visit	Date(s)of Hospitalization

Continued on the next page

6. EDUCATION, TRAINING AND EXPERIENCE INFORMATION
(Attach copy of current resume or complete information where applicable.)

Highest grade level of education completed _____ Technical/ Trade School _____ Type of Diploma obtained _____

College/ University _____ Years completed _____ Type of Diploma obtained _____ Year _____ Major _____

Briefly describe types of employment held in last 15 years: _____

_____

List any technical, administrative or special interest courses taken: _____

_____

_____

List skills acquired in current and previous positions:
(e.g. typing, operation of equipment, supervisory skills, special licenses or designations) _____

_____

_____

7. If applicable, I hereby authorize relese of my name to my union as a Long Term Disability Claimant

Signature of Employee: _____ Date: _____

8. ASSIGNMENT, CERTIFICATION AND AUTHORIZATION (SIGNATURE REQUIRED)

I certify that the information in this form is true and complete. I understand the Claims Administrator may investigate this claim. I authorize my employer, physician, practitioner, health care professional, hospital, health care institution, medical organization, clinic and any other medically-related facility, insurance company, Worker's Compensation authority, Canada or Quebec Pension Plan, group plan administrator, employer-sponsored pension plan administrator, to release and exchange with the Claims Administrator and the Plan Administrator any medical or benefit payment information to process or manage my claim. I agree that a photocopy of this authorization shall be as valid as the original. I understand that any charges for having forms completed or medical reports are my responsibility.

If you have any questions about the collection and use of this information, contact Vestcor's Member Services team, by mail at P.O. Box 6000, Fredericton, NB, E3B 5H1, by phone at (506) 453-2296 or 1-800-561-4012, or by email at info@vestcor.org. In addition, please note that Vestcor's Privacy Statement is available at vestcor.org/privacy.

Signature of Employee: _____ Date: _____

Address and Postal Code: _____

_____ Tel. No.: _____